Patient-Centered Medical Home and the Future of Medical Care in Montana

A series of Webinars for the Primary Care Providers of Montana created and presented by Primary Care Providers of Montana

Monica J. Lindeen
CSI
Montana Commissioner of Securities & Insurance

Webinar #2 – Dr. Ed Wagner

Ed Wagner, MD, MPH, MACP is a general internist/epidemiologist and Director of the MacColl Institute for Healthcare Innovation at the Group Health Research Institute in Seattle. His research and quality improvement work focus on improving the care of individuals with chronic illness and cancer. He and his MacColl Institute colleagues developed the Chronic Care Model (CCM), an integral part of the Patient-centered Medical Home Model (PCMH), and are involved in multiple efforts to use these models to improve ambulatory care nationally and internationally. He has written two books and 300 peer-reviewed publications. He is an elected member of the Institute of Medicine of the National Academies. Dr. Wagner was the recipient of the 2007 NCQA Health Quality Award, the 2007 Picker Institute Award for Excellence in Patient-centered Care, and the 2011 William B. Graham Prize for Health Services Research.

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The Fourth Aim:

Primary Care and the Future of American Medical Care

Ed Wagner, MD, MPH, MACP

MacColl Institute for Healthcare Innovation
Group Health Research Institute

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We live in interesting times

- **Federal healthcare reform is counting on a robust primary care sector to improve quality, reduce costs, and improve patient experience (the triple aim).**

  “The Patient Protection and Affordable Care Act (PPACA) of 2010 brings both promise and peril for primary care. This Act has the potential to reestablish primary care as the foundation of US health care delivery.”*

*Goodson J. Ann Int Med. 2010; 152:742

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BUT,

- **Primary care appears to be dispirited, provides mediocre quality, and is rapidly diminishing in size.**

*Goodson J. Ann Int Med. 2010; 152:742

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Dispirited?

- 36% of US PCPs are not satisfied with practicing medicine compared to 11-12% in Norway, New Zealand, or Netherlands, and 19% in the UK.

Source: 2009 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

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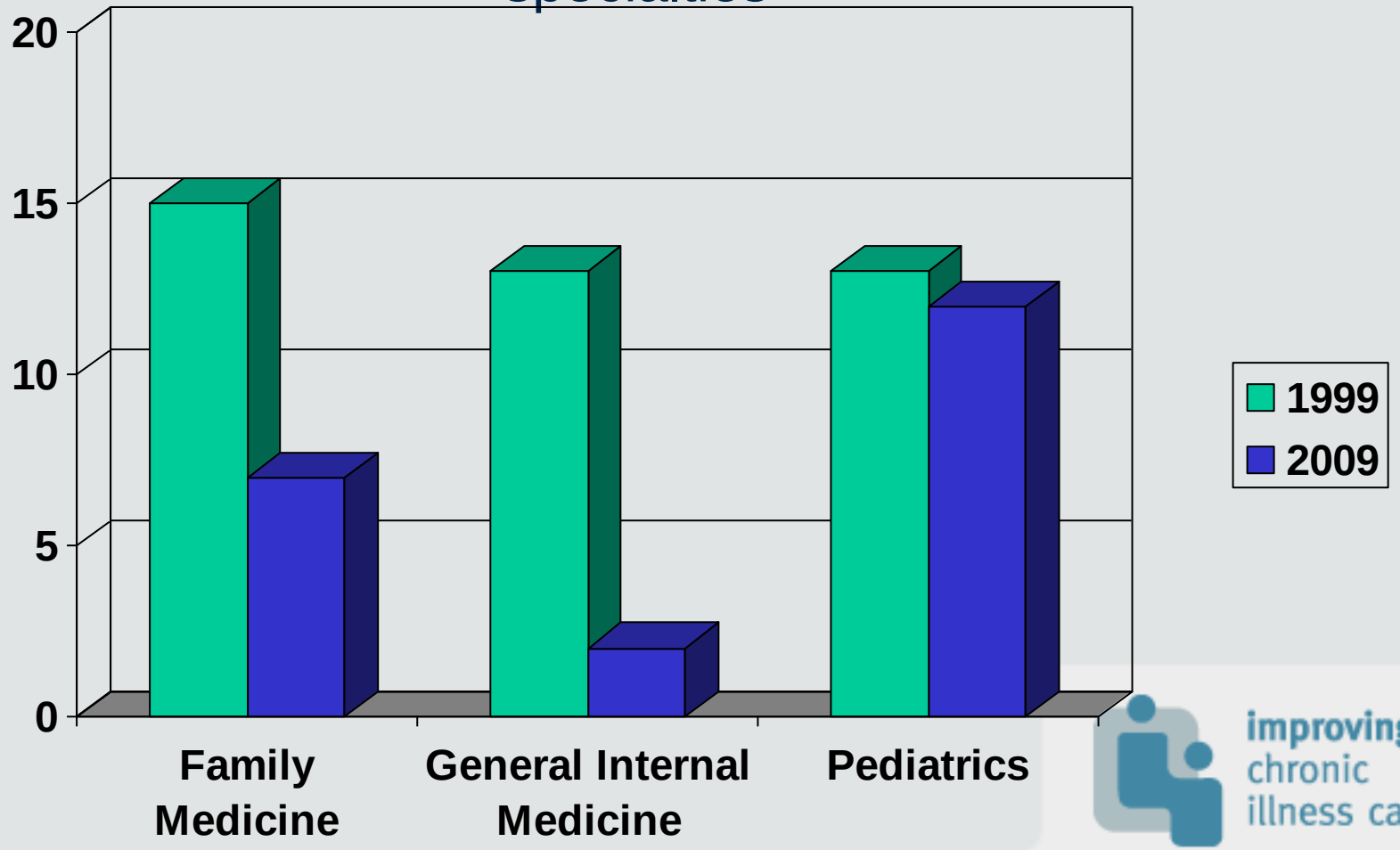
Diminishing?

Percentage of medical students choosing primary care specialties



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Primary Care — Will It Survive?

And will it matter if it doesn't

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Primary Care's Decline: Does it Matter?

- 95% of individuals report that it is important that they " have one practice/clinic where doctors and nurses know you, provide and coordinate the care that you need".
- Countries with better primary care have better health outcomes and lower costs
- States with higher primary care/ population ratios have lower costs and better quality

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What's Threatening Primary Care?

- Changing demography and practice content increasing demand
- Greater care complexity
- Declining real income
- Working harder and harder just to keep up

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What to do?

- The future of primary care (and our healthcare system) depends upon its ability to improve quality (first aim) and reduce costs (second aim), especially for the chronically ill.
- It will also require a recommitment of primary care to meet the needs of patients for timely, patient-centered, continuous and coordinated care (third aim--improve patient experience).
- This will require a **major transformation or redesign of practice**, not just an EMR and better reimbursement.
- But such transformations will be difficult to implement ot or sustain without strong motivation.

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Provider Joy in Work—the Fourth Aim?

Provider dissatisfaction:

- Reduces patient satisfaction;
- Increases risk of retirement or reducing hours;
- Increases turnover and reduces continuity;
- Contributes to staff unhappiness; and
- May increase costs.

BUT MAY BE A STRONG MOTIVATOR FOR CHANGE

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A New Model to Save Primary Care?

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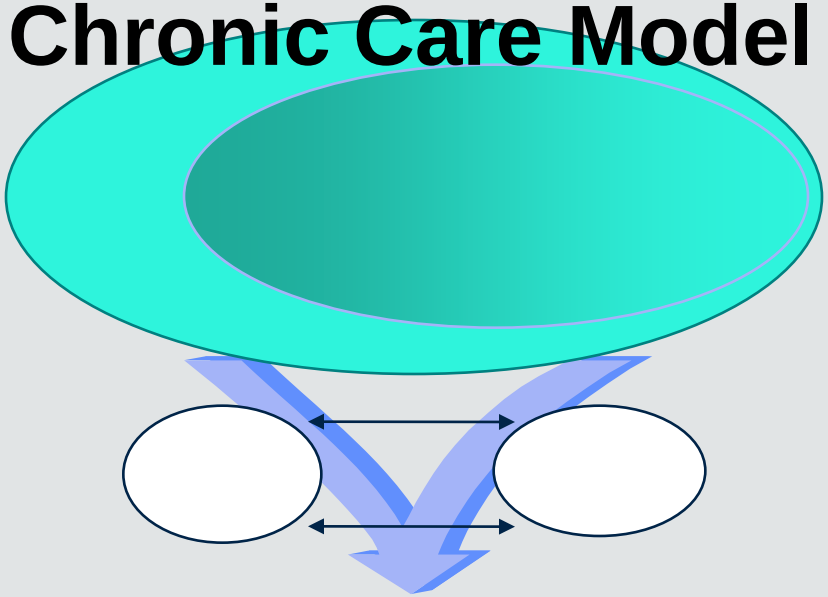
The major primary care professional organizations proposed the Patient-centered Medical Home

- An Amalgamation of the Pediatric Medical Home and Chronic Care Models

Chronic Care Model



Improved Outcomes

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Medical home – Chronic Care Model
Duplicative, Complementary or Antagonistic?

- Both emphasize and support patient role in decision-making and care
- PMH underscores primary care's responsibility for access, continuity, comprehensiveness, and coordination
- CCM redesigns care delivery for planned, whole person care
- Both models advocate that every health care experience (visit, referral, admission,etc) connects the patient back to their PCP.

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What are the key features of a Patient-Centered Medical Home?

- Engaged leadership
- Quality improvement strategy
- Empanelment (linking each patient with a provider)
- Enhanced access
- Continuous, team-based healing relationships
- Patient-centered interactions
- Organized, evidence-based care
- Care coordination

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Aren’t we all Patient-centered Medical Homes?

- Only 46% of US PCPs have an EMR compared to 95+% in the Netherlands, UK, and New Zealand.
- Only 30-40% of US PCPs have the capacity to generate a list of patients with a disease or generate a drug list compared with the majority of MDs in most other developed countries.
- Only 29% of US PCPs have arrangements for patients to see a provider after hours compared to 89% or more in Neth, NZ, and UK.
- Less than 50% of US PCPs have data on the quality of their care.
- 59% of US PCPs use nonphysician staff for patient care compared to 98% in the UK and Sweden.

Source: 2009 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

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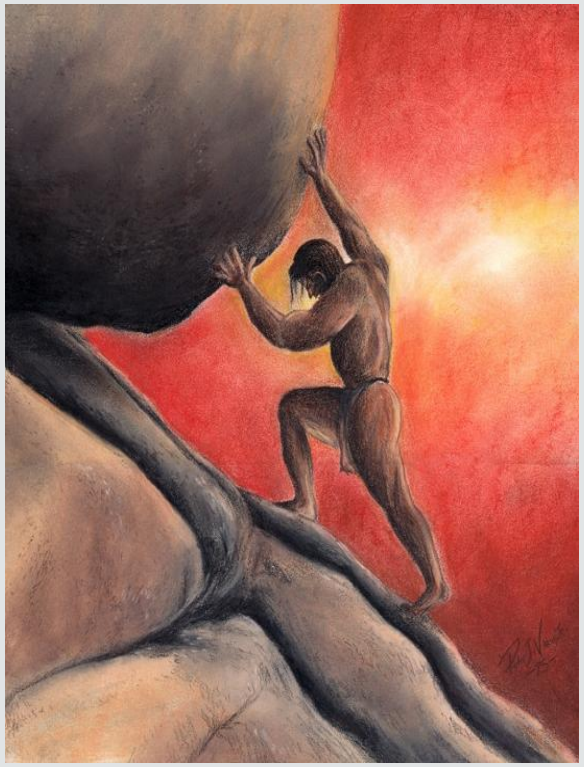
How does a practice become a PCMH?

"Change is hard enough; transformation to a PCMH requires epic whole-practice reimagination and redesign."*

"The magnitude of stress and burden from the unrelenting, continual change required to implement components of the [PCMH] model was immense."**



***Nutting et al. Ann Fam Med. 2009; 7:254-260**

****Nutting et al. Ann Fam Med. 2010; 8 (Supp 1): S45-S56.**

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Why is practice change so hard?

- Practices are complex, adaptive systems with interdependent processes and systems; a change to one aspect (e.g., a staff role) affects others.
- Medical practice is inherently stressful, and established routines and patterns limit stress even if flawed.
- Transformation to a PCMH asks physicians and other staff to change their roles and identities, the way they deliver care, and how they relate to one another.

Major Challenges to Implementation of the Patient-centered Medical Home Model

- Requires intensive QI effort and committed local leadership
- Limited involvement of non-physician staff in clinical care
- Lack of established IT with critical functions associated with better care, especially registries
- Lack of performance measurement
- Perverse payment system

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Group Health's Journey to the Patient-centered Medical Home

- Raised primary care panel size 20-25% in 2002-3
- Specialist visits/pt increased 25%
- ER visits/pt doubled
- Staff satisfaction fell
- Physician mean FTE fell 5-10%
- Quality indicators either stayed flat or fell

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Group Health PCPs in the NY Times

- **"All day long it would be frenetic, all out of control; then afterward, you'd chart on everybody and do phone calls," Spencer recalls.**
- **One night, "I was sitting in my office at about 8 p.m., thinking: 'I'm not sure I can do this anymore."**
- **"It had lost all its pleasure," says Seaver, 41, who had been thinking about leaving primary care. "I wasn't given the time or the opportunity to provide the right level of care without a huge sacrifice on my part."**

Dr. Harry Shriver

- Wonderful family physician, medical director of Factoria Clinic,
- Was burnt out, ready to retire,
- Counseled his medical student daughter to avoid primary care specialties,
- But was willing to give practice transformation a try.

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Group Health's Patient-centered Medical Home Pilot

- Reduced primary care panel size back to pre 2002-3 levels
- Raised appointment slots from 20 to 30 minutes
- Encouraged use of virtual medicine
- Improved chronic care management—team care, use of registries, reminders, promotion of self-management support
- Visit preparation—review record and huddle to plan care
- Patient outreach—new patients, unmet care needs, post ER or hospital discharge
- Rerouted phone calls to care team

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Did the Group Health pilot achieve the quadruple aim?

Patient Experience	Improved patient experience in access, care coordination, chronic illness care.
Staff Burnout	Significant reductions in emotional exhaustion and depersonalization.
Clinical Quality	Significant improvement across 22 quality indicators.
Utilization	PCP visits declined 6% but pt. contact increased by e-mail and phone. Specialty use increased initially. ER and hospital use 29% and 6% less, respectively.
Costs	Total costs $10.30 pmpm less than control clinics.

In most QI collaboratives, one-half or more of participating practices show no evidence of improvement.

But, a sizable minority do show improvement in important outcomes.

What distinguishes those that improve from those that don't?

Transformed practices are motivated

Extrinsic Motivators	Intrinsic Motivators
Public reporting	Pride in performance
Management edict	Want to be leaders
Financial incentives	Joy in work

Transformed Practices involve staff in a proven Change Strategy

- Practices that have improved have a strategy for continuous improvement and a culture that supports it.
- Practices that have improved broadly engage staff in the improvement process—both design and execution.
- Such engagement leads to more realistic and sustainable changes, and is a morale booster in itself.

Message: Transformation is a function of activity and engagement.

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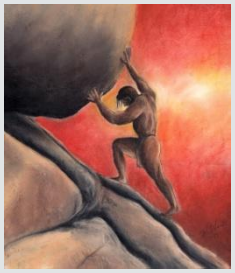
Responses to Provider Dissatisfaction

Retirement or Reduced Hours



Practice Transformation

Naysaying

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Joy in Work – powerful motivator and important outcome

- The driving force behind the Group Health PCMH pilot was staff burn-out. More satisfied providers and staff were critical outcomes.

- In our Academic Chronic Care Collaboratives, practices that showed improvement:

  - **continuously linked their improvement activities to their individual and institutional missions as care providers, and their work satisfaction.**

- "I am responsible for scheduling our diabetic patients for our Chronic Disease Management Clinic…this is such an important task and a lot of our success hinges on what I do."

Johnson et al. JGIM. 2010; 25 (Suppl 4): 581-5.

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Joy in work

- Improving staff satisfaction appears to be a powerful motivator for change.
- If staff perceive their work life to improve, it invigorates QI efforts.

Message: We should re-orient QI efforts to focus more on its impacts on staff.

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Successful practice transformation

- Recognizes its difficulty and prepares practices for it.
- Includes a focus on the experience of those providing care.
- Assures that routine care delivery is different.
- Involves staff and patients in continuous process change.

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What did becoming a medical home do for Drs. Seaver and Shriver?

- **"It had lost all its pleasure," says Seaver, 41, who had been thinking about leaving primary care. "I wasn't given the time or the opportunity to provide the right level of care without a huge sacrifice on my part."**

- **At Factoria, "I get up in the morning looking forward to work. I enjoy seeing my patients . . . and I can actually see myself practicing primary care for a long time in this type of environment.“**

- **Harry decided not to retire, and is still practicing. Has become a PCMH advocate.**

- **His daughter practices Family Medicine in the same clinic.**

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Contact us:

- www.improvingchroniccare.org
- **www.safetynetmedicalhome.org**

thanks

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Dr. Stefanie Lange

- Stefanie Lange, MD, MPH is originally from the Twin Cities in Minnesota
- Her love for Montana was born in the Paradise Valley where she worked during her summers off from college
- Stefanie completed the MD/MPH program at Tulane University
- She returned to Montana to work at Community Health Partners following residency in St. Paul, MN.
- Stefanie is CHP's interim medical director for this year while continuing her clinical practice in Family Medicine, supported by her husband and four children.

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Provider Testimonial

- What is it really like to practice in a medical home?
  - A Montana Success Story

Dr. Stefanie Lange,

Medical Director of the CHC at Livingston/Bozeman/Belgrade/ West Yellowstone

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Next Webinars

- Webinar #3 - NCQA Standards, a guide to recognition for your practice, and resources for change (May 1st)
- Webinar #4 - Framework for Payment, a guide for payer/provider contracts for PCMH (May 15th)
- Webinar #5 - Quality Metrics, benchmarks the council is considering for measuring performance (May 31st)

Resources

- CSI *800-332-6148*
  - www.csi.mt.gov
- Regional Extension Center (REC) *406-457-5888*
  - www.healthtechnologyservice.com
- Mountain Pacific Quality Health *406-443-4020*
  - www.mpqhf.org
- Health Share MT *406-794-0170*
  - www.healthsharemontana.org
- NCQA *202-955-5128*
  - www.ncqa.org

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Thank you for joining the webinar today! Questions?

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